Workers' Compensation Carrier Request

(888) CalPERS (225-7377) • Telecommunications Device for the Deaf: (916) 795-3240 • Fax: (916) 795-1280

Section 1 — Member Information

You must complete the front side of this form, sign, date and forward to your Workers' Compensation Insurance Carrier.

If you have filed a Workers' Compensation claim for the illness or injury directly related to the application for Disability or Industrial Disability Retirement, this Workers' Compensation Carrier Request form (reverse side) must be completed by your employer's Workers' Compensation Insurance Carrier.

Name of Member (First Name, Middle Initial, Last Name) | Social Security Number

Employer Name

Claim Number 1 | Date (mm/dd/yyy) | Body Part(s)

Claim Number 2 | Date (mm/dd/yyy) | Body Part(s)

Claim Number 3 | Date (mm/dd/yyy) | Body Part(s)

Claim Number 4 | Date (mm/dd/yyy) | Body Part(s)

Section 2 — Authorization to Release Information

Send this form directly to your Workers' Compensation Carrier. They will complete the reverse side of this form and send the requested information to CalPERS.

I have submitted an application for disability/industrial disability retirement with the California Public Employees' Retirement System (CalPERS). You are hereby authorized to furnish CalPERS, or its representative, any and all information, including photocopies of records in your possession, which CalPERS requires solely to assist in determining my physical or mental condition, illness, or disability. The purpose of this authorization is to assist CalPERS in determining my right to retirement or reinstatement under the Retirement Law pursuant to Government Code Sections 20128; and no other purpose. This authorization shall be valid for four years from the date shown below. A photographic copy of this authorization shall be as valid as the original.

Signature of Member | Date (mm/dd/yyyy)

This form continues on the back.

Applicant's Name | Social Security Number

Section 3 — To Be Completed By Workers' Compensation Carrier

Your help is needed in the evaluation of my eligibility for disability or industrial disability retirement.

Be sure to send CalPERS a copy of all medical reports for the claim number(s) listed. Include job descriptions/ job analyses, depositions, investigation reports, videotapes, and approved orders from the Workers' Compensation Appeals Board.

Claim Number 1 | WCAB Number | Date of Injury(mm/dd/yyyy)

Body Part(s) | ☐ No ☐ Yes Liability Accepted | ☐ No ☐ Yes Condition P&S

Claim Number 2 | WCAB Number | Date of Injury(mm/dd/yyyy)

Body Part(s) | ☐ No ☐ Yes Liability Accepted | ☐ No ☐ Yes Condition P&S

Claim Number 3 | WCAB Number | Date of Injury(mm/dd/yyyy)

Body Part(s) | ☐ No ☐ Yes Liability Accepted | ☐ No ☐ Yes Condition P&S

Claim Number 4 | WCAB Number | Date of Injury(mm/dd/yyyy)

Body Part(s) | ☐ No ☐ Yes Liability Accepted | ☐ No ☐ Yes Condition P&S

If liability is not accepted, provide reason (Reference Claim Number) _____

If condition is not permanent and stationary, what is estimated time period or date? (Reference Claim Number)

Has settlement occurred? ☐ Yes ☐ No

If Yes, ☐ Stipulated Award _____ % Claim Number(s) _____

☐ C&R $ _____ Claim Number(s) _____

☐ F&A _____ % Claim Number(s) _____

Is there a possibility of third party liability? ☐ Yes ☐ No

Are you in the process of, or have you completed any investigations? ☐ Yes ☐ No If Yes, provide copies.

Are further exams scheduled? ☐ Yes ☐ No

Name of Doctor | Specialty | Appointment Date

☐ AME ☐ QME ☐ Treating Physician ☐ Other _____

Please use additional sheets to supply any additional background, information, or comments.

Name of Doctor | Specialty | Appointment Date

☐ AME ☐ QME ☐ Treating Physician ☐ Other _____

Section 4 — Signature of Workers' Compensation Carrier

Signature of Workers' Compensation Representative | Date (mm/dd/yyyy)

Print Workers' Compensation Representative's Name | ( ) Phone Number

Mail to: **CalPERS Benefit Services Division** • P.O. Box 2796, Sacramento, California 95812-2796